

EIGHTH DISTRICT ELECTRICAL BENEFIT FUND

P.O. Box 30101 – Salt Lake City, Utah 84130-0101
2156 West 2200 South – Salt Lake City, Utah 84119-1376
Telephone 801-973-1001
Toll Free 1-800-628-6562

The enclosed documents are in regards to your Personal Care Account (PCA).

The first form is the automatic reimbursement form, which requires completion each year by the Member if you are authorizing checks to be automatically sent to you from your PCA. With this form, the only claims you will have to submit for would be reimbursement for prescription co-pays and routine vision claims (i.e. exams, glasses, contacts etc.). The original form must be mailed to our office.

The second form is a reimbursement request form. One form is required for each dependent you are submitting claims for. You can attach as many bills, EOB's, balance due statements (as long as the patient name, date of service and provider's name are visible) to the reimbursement request form as you want. This form must be signed and dated by the Member.

Additional information regarding the Personal Care Account:

Claims must be submitted for reimbursement from your PCA by March 30, 2009 for expenses incurred in 2008.

The Member must have eligibility with the Eighth District Electrical Benefit Fund at the time of submission of claims to the Personal Care Account.

Safety glasses when needed by the Member for his/her employment are now a covered benefit.

When submitting for prescription reimbursement, the "actual" pharmacy receipt is required, not the register receipt.

If you have any questions regarding the Personal Care Account reimbursement or the enclosed forms, please contact the Administrative Office at: (800) 628-6562.

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PERSONAL CARE ACCOUNT AUTOMATIC REIMBURSEMENT REQUEST FORM

Yes, I authorize the Administrative Office to automatically reimburse me the outstanding balances regarding any Medical or Dental claims that have been processed by the Eighth District Electrical Benefit Fund and which are allowed under the rules and regulations for the Personal Care Account for the calendar year of 2009. Automatic reimbursements will be done twice a month.

All payments will be made to the employee. The minimum amount a check can be issued for is \$25.00.

Employee Signature

Date

Please print name

ID# (Encrypted # or Soc. Sec. #)

Member's Address

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.



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PERSONAL CARE ACCOUNT REIMBURSEMENT REQUEST FORM

1. Type or print information (items 1 through 8) on the Employee Section below. Only one patient can be listed on a request form. However, more than one provider can be listed for that one patient.
2. Enter the total amount for which the claim is being made in the appropriate sections. A minimum of \$25 should be accumulated before you submit a claim.
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:
 - Explanation of Benefit Statement(s) indicating deductibles, co-insurance, co-payment or amounts in excess of usual and customary charges from any medical/dental plan(s) under which you and/or any of your eligible dependents are covered, or if the expense is not covered under your medical/dental plan, itemized bills from doctors, dentists or other suppliers for insured expenses.
4. Retain copies of supporting documentation for your records.
5. Send completed claim form and supporting documentation, in a personal and confidential envelope, to the Administrative Office at the address above.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.

1. Employee's Name	2. Social Security Number	3. Address
4. Patient's Name	5. Relationship	
6. Provider Name(s)	7. Local Union	
8. I have medical coverage through the Eighth District Electrical Benefit Fund:		YES <input type="checkbox"/> NO <input type="checkbox"/>

UNREIMBURSED HEALTH CARE EXPENSES

	Date of Service	Claim Amount to be Reimbursed
Deductible		\$
Co-Insurance/Co-Payments		\$
Not Covered by Plan		\$
Total (Minimum \$)		\$

I certify that either I, and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Health Care Reimbursement Account. Further, I declare that I have not and will not deduct these expenses on my individual income tax returns. No assignment will be accepted. All payments will be made to the employee through payroll.

Employee Signature

Date

